Data Collection Instructions - MHCC January 2009 through December 2009

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Registration Form				
Date	Date on qualifying ECG	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2008-2009)	* Qualifying ECG	
Initials	Patient initials	First, middle, last initial	* Face sheet * Qualifying ECG * Emergency department record	Space for 3 initials. First and last initials are acceptable.
Medical Record Number	Patient's unique alpha-numeric number assigned by the hospital to facilitate retrieval of individual patient records	Patient's Medical Record Number	* Face sheet	The unique medical record number is to be assigned permanently to the patient and may not be changed.
Documented STEMI	ECG demonstrated ST-segment elevation myocardial infarction	-Yes -No	* Qualifying ECG	Scanned documentation not necessary.
Previously registered		-Yes -No		If the patient was previously registered (yes), enter last MHCC Registry number.
MHCC Registry Number			* Registry database	
Patient source	The location of the patient prior to admission or transfer	1. On-site ED 2. On-site CCU 3. Other on-site hospital unit/ward 4. On-site outpatient location (e.g., clinic) 5. Transfer from another acute care facility 6. Transfer from a non-acute care facility 7. Off-site outpatient facility	* Emergency department record * History and physical * Registration form * Face sheet * Transfer sheet	- On-site ED: The patient was admitted via the Emergency Department. - Transfer from Non-Acute Care Facility: The patient was admitted by transfer from a chronic or rehabilitation hospital, skilled nursing facility or nursing home.
Did the patient go emergently to the catheterization lab at this hospital?	At your hospital (MHCC registry participating hospital)	-Yes - No		
COMPLETE THE FOLLOWING QUESTIONS ONLY IF YOU ANSWERED 'NO' ABOVE				
If patient did NOT go to the cath lab	Patient did NOT go to the cath lab at your hospital	1. Died before any PCI or lytic could be given 2. Signs/symptoms of ischemia resolved prior to transfer to cardiac catheterization laboratory 3. Received thrombolytic therapy 4. Received medical therapy, but neither PCI nor thrombolytic therapy 5. Cath lab not available for PCI 6. Staff (MD, RN, tech) not available for PCI 7. Other reason PCI not performed at this hospital (explain in comments) 8. Severe comorbid condition(s) 9. Late or indeterminate time to presentation 10. Physician preference 11. Patient preference (refusal)	* Emergency department record * History and physical * Progress notes * Consultation notes	If 'no' for the cath lab, choose one of the reasons; explain 'other reason' in comments.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Disposition	Status of the patient when service ended; the place or setting to which the patient was discharged	1. Admitted to this hospital 2. Transferred to another hospital 3. Discharged home from ED 4. Left against medical advice 5. Died 6. Other (explain in comments)	* Emergency department record * Progress notes * Consultation notes	What happened to the patient? Explain 'other' disposition in comments.
Comments				Record all appropriate comments relevant to patient care.

Please note:
1. **COMPLETE ONLY THE REGISTRATION FORM** if patient died in ED/or before tx could be applied **OR** patient was transferred out prior to tx **OR** received neither PCI nor lytics (but stayed in participating site hospital)

2. **COMPLETE ALL OTHER FORMS** if patient went to cath lab (regardless of whether PCI was done or not) **OR** if lytics received.

Demographic Data				
Patient Date of Birth	The month, day, and year the patient was born	MM = Month (01-12) DD = Day (01-31) YYYY = Year	* Emergency department record * Registration form * Face sheet	Patient's age (in years) is calculated by ADMISSION DATE minus Birthdate. The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age. Automated birthdate audit by the data collection software: at least 18 years of age; upper limit = 100.
Gender	The patient's sex/gender at birth	M Male F Female	* Emergency department record * Registration form * Face sheet * History and physical * Nursing admission notes * Progress notes * Consultation notes	
Race	Patient's race as determined by the patient/family	- White - Black or African-American - Asian - Native Hawaiian or Other Pacific Islander - American Indian or Alaska Native - Other - Unknown	* Emergency department record * Registration form * Face sheet * History and physical * Nursing admission notes * Progress notes * Consultation notes	If more than one race is given, the FIRST RACE declared by the patient is to be entered.
Ethnicity	Patient's ethnicity as determined by the patient/family	- Hispanic or Latino - Not Hispanic or Latino - Unknown	* Emergency department record * Registration form * Face sheet * History and physical * Nursing admission notes * Progress notes * Consultation notes	Hispanics and Latinos may be of any race.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Patient ZIP	The five-digit ZIP Code assigned by the Postal Service to the patient's principal or usual residence at the time of admission	77777 Foreign 99999 Unknown	* Face sheet * Registration form	
Patient State	The State in which the patient's principal or usual residence is located at the time of admission	The official United States Postal Service (USPS) two-letter State Abbreviations for US states, territories and possessions. XX If other than United States 99 Unknown	* Face sheet * Registration form	If the patient is a noncitizen who is not residing in the United States, enter XX.
Patient SSN	The patient's nine-digit Social Security Number (SSN)	XXX-XX-XXXX	* Face Sheet * Registration form	If patient may have a Social Security Number but it is unavailable, enter UUU/UU/UUUU. If patient does not have a Social Security Number (infant under the age of 2 or is not a US citizen), enter III/II/IIII.
Index Hospital Name	The full name of the facility where the percutaneous coronary intervention (PCI) procedure was performed. [Note: For AMI patients, the patient received in-hospital cardiac medical therapy and/or diagnostic or interventional procedures.]	Values should be full, official hospital names with no abbreviations or variations in spelling for a single hospital.		Drop down box generated by the data collection software.
Index Hospital ID (MPN)	The hospital's six-digit acute inpatient Medicare provider identifier	The valid six-digit Medicare provider number assigned to the hospital.		Automated entry (pre-populated) by the data collection software.

Please note:
No later than May 23, 2007, a health care provider who bills Medicare for services is required to use a **National Provider Identifier** (NPI), which is a 10-digit number (9 numeric digits followed by one numeric check digit). Health care providers include individuals, such as physicians, and organizations, such as hospitals. Sites should begin using the NPI in lieu of the legacy provider identifier on the compliance date.

Hospital Account Number	The account number the hospital allocates to the specific patient admission		* Face sheet	

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Initial Hospital Data - Past Medical History and Risk Factors				
Prior history of MI	Patient has had at least one documented previous STEMI or NSTEMI EIGHT or more days prior to this admission.	- Yes - No - Not documented	* Emergency department record * History and physical * ECG reports * Consultation notes	ST elevation myocardial infarction (STEMI) or Non ST elevation myocardial infarction (NSTEMI): This can be coded based on physician documentation or history noted in the medical record. Scan ED record and H & P.
Prior history of stroke	The patient has a documented history of stroke or cerebrovascular accident.	- Yes - No - Not documented	* Emergency department record * History and physical * Consultation notes	Patient has a history of stroke, i.e., neurological deficit present at admission and noted on any admission history or physical exam performed at the time of admission. A neurological deficit requires objective determination of aphasia, paralysis, paresis, ataxia, or blindness.
Prior history of CABG	The patient has a history of previous Coronary Artery Bypass Graft Surgery by any approach.	- Yes - No - Not documented	* Emergency department record * History and physical * Consultation notes	
Prior history of PCI	The patient has a previous percutaneous coronary intervention (even if unsuccessful) of any type (balloon angioplasty, stent or other), performed prior to the current admission.	- Yes - No - Not documented	* Emergency department record * History and physical * Consultation notes	
Diabetes	The patient has a history of diabetes, regardless of duration of disease, or need for antidiabetic agents.	- Yes - No - Not documented	* Emergency department record * History and physical * Consultation notes	This includes diagnosis on admission or pre-procedure. It does not include gestational diabetes.
Initial Hospital Data - Intake Physical Exam				
Weight (kg)	The weight of the patient in kilograms	A continuous variable measured to the nearest tenth of a kilogram (0.1 kg).	* History and physical * Nursing admission notes * Cath lab log	Initial Value: first weight closest to time of arrival. Scan sheet with weight and height.
Height (cm)	The patient's height in centimeters	A continuous variable measured to the nearest tenth of a centimeter (0.1 cm).	* History and physical * Nursing admission notes * Cath lab log	Initial Value: first height documented in the medical record.
Heart rate	The patient's pulse rate as documented at the time of the initial assessment	A continuous variable measured in beats/minute.	* Emergency department record * Graphic report * Progress notes	In ED, first pulse documented on triage sheet or other ED record. From other location, pulse documented on flow sheet/progress note closest in time to ECG showing STEMI.
Blood pressure	The patient's blood pressure as documented at the time of the initial assessment	A continuous variable measured in (systolic)/(diastolic) mmHg.	* Emergency department record * Graphic report * Progress notes	In ED, first blood pressure documented on triage sheet or other ED record. From other location, blood pressure documented on flow sheet/progress note closest in time to ECG showing STEMI.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Creatinine (Serum)	The patient's most recent creatinine level, assessed on admission or prior to PCI procedure	A continuous variable measured in mg/dl.	* Laboratory report	Initial (preferably ED) value closest to time of arrival, documented on dated/timed lab report only. Creatinine should be collected on all patients for consistency, even if they have no prior history of renal failure. Scan lab report.
Initial Hospital Data - Thrombolytic Therapy				
Thrombolytic eligible?	The patient has no reason why he or she is unable to receive thrombolytic therapy, that is, the patient does not have a high risk of bleeding or any contraindications to thrombolytics.	- Yes - No	* Emergency department record * History and physical * Medication administration record * IV flow sheets * Medication administration record * Nursing notes * Transfer sheet	
If ineligible, check all that apply:	The patient is unable to receive thrombolytic therapy.	- Evidence or history of active bleeding (other than menses) - Systolic blood pressure > 180 mmHg - Diastolic blood pressure > 110 mmHg - ST-segment depression (unless true posterior infarction is suspected) - Recent (within 6 weeks) trauma or surgery - Prior stroke or recent CNS symptoms - Incompressible arterial puncture - Known intraventricular thrombus - Other	* Emergency department record * History and physical * Medication administration record * Nursing admission assessment * Transfer sheet	Explain 'other' reason (free text).
Thrombolytic initiated?	The patient received thrombolytic therapy.	- Yes - No	* Ambulance record * Emergency department record * ICU/nursing flow sheets	
If thrombolytic given = yes, time and date initiated	The date and time (military time) that thrombolytic therapy started	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2008-2009) HH = Hour (00-23) MM = Minutes (00-59) Military Time - a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.	* Ambulance record * Emergency department record * ICU/nursing flow sheets * IV flow sheets * Medication administration record * Nursing notes * Transfer sheet	* If there were 2 different thrombolytic administration episodes, enter the time the earliest thrombolytic was initiated during this hospital stay. * In the event the patient was brought to the hospital via ambulance and thrombolytic therapy was infusing at the time of hospital arrival, enter the time the patient arrived at this hospital.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Use of thrombolytic therapy as primary therapy, facilitated, adjunctive, or other	Describe whether thrombolytic therapy was administered as the primary therapy, or used to facilitate PCI or as an adjunctive.	- Primary therapy - Facilitated PCI - Adjunctive during PCI procedure - Other	* Ambulance record * Emergency department record * ICU/nursing flow sheets * IV flow sheets * Medication administration record * Nursing notes * Transfer sheet	Explain 'other' use (free text).
Use of thrombolytic therapy as monotherapy, combination therapy, or other	Describe whether thrombolytic therapy was administered as monotherapy or combination therapy.	- Full dose monotherapy - Half dose combined with GPIIb/IIIa antagonist - Other	* Ambulance record * Emergency department record * ICU/nursing flow sheets * IV flow sheets * Medication administration record * Nursing notes * Transfer sheet	Explain 'other' use (free text).
Initial Hospital Data - Time Data				
Time and date of Symptom Onset	The time and date of the documented onset of symptoms that led to identification of acute MI	- Indeterminate MM = Month (01-12) DD = Day (01-31) YYYY = Year (2008-2009) HH = Hour (00-23) MM = Minutes (00-59) Military Time - a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.	* ED documentation (includes ED/Outpatient Registration form or triage record) * Nursing admission assessment/admitting note	Time of onset of those symptoms that led the patient to present for treatment or that led to identification of the current MI. Where there was a prodrome of intermittent pain, report when the last sustained period of intermittent pain commenced.
Time and date on first ECG showing ST-segment elevation	Enter time and date on first ECG showing ST-segment elevation.	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2008-2009) HH = Hour (00-23) MM = Minutes (00-59) Military Time - a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.	* ECG report	Scan qualifying ECG and entry ECG if required.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Did the patient arrive at the hospital through the ED?	The patient arrived at the hospital through the Emergency Department.	- Yes - No	* ED documentation (includes ED/Outpatient Registration form or triage record) * Nursing admission assessment/admitting note	
If yes, time and date of ED Arrival	The time and date of the patient's arrival at the ED of the facility performing the PCI	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2000-9999) HH = Hour (00-23) MM = Minutes (00-59) Military Time - a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.	* Any ED documentation (includes ED vital sign record, ED/Outpatient Registration form or triage record) * Nursing admission assessment/admitting note	The time noted on the triage sheet.
If arrival through ED - STEMI on arrival?	Patient comes in with chest pain and has ST-segment elevation on the first ECG.	- Yes - No	* ECG report	If STEMI on arrival has been answered as "no," an entry ECG is required.
Clock start	The date and time clock start indicated	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2008-2009) HH = Hour (00-23) MM = Minutes (00-59) Military Time - a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.		**ED door date/time **OR** **ECG showing ST elevation date/time if first is NOT qualifying **OR** **Cath Lab arrival date/time if field ECG qualifying and bypass ED. **Transfer hospital qualifying ECG date/time if transferred in from another hospital.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Transfer for Primary PCI at this facility	The patient was received as a transfer from another facility's emergency department.	- Yes - No	* Discharge summary * Nursing discharge notes * Transfer record	
If the patient was transferred from another facility for PCI, time and date of ED presentation at referring facility	The time and date of arrival at the original, transferring facility as documented in the medical record, or the initial onset of ST elevation MI symptoms that occurred at the transferring facility, if it occurred after admission to the transferring facility	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2008-2009) HH = Hour (00-23) MM = Minutes (00-59) Military Time - a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.	* Discharge summary * Nursing discharge notes * Transfer record * ED record	
STEMI on arrival at referring hospital	Patient arrived at referring hospital with ST-segment elevation on the first ECG.	- Yes - No	* ECG report	
If patient transferred from another hospital, time and date of the first ECG showing ST segment elevation.	The time and date of the first ECG showing ST-segment elevation	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2008-2009) HH = Hour (00-23) MM = Minutes (00-59) Military Time - a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.	* ECG report	**This date and time will be reported as clock start time.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Time and date of Cath Lab Arrival (Table time)	The date and time the patient is logged in as arriving in the catheterization laboratory (table time)	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2008-2009) HH = Hour (00-23) MM = Minutes (00-59) Military Time - a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.	* Procedure notes * Cath lab log sheet	This should not be the date/time of the patient arriving at the cath holding area.
Time and date of First Balloon	The time of first inflation of any device (balloon or stent) in the infarct-related artery. The first device used to open the IRA may be a thrombectomy device.	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2009) HH = Hour (00-23) MM = Minutes (00-59) Military Time - a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.		Provide comments as appropriate.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Angiography and PCI Form				
PCI Primary Operator's Name	The PCI Operator's full name	Free text	* Cath lab log sheet * Cath/PCI report	Enter PCI Operator's last name, followed by a space, followed by the first name.
PCI Primary Operator's UPIN	The physician's Unique Physician Identification Number (UPIN)	The valid six-digit UPIN assigned to the physician	* Cath lab log sheet * Cath/ PCI report	UPIN, assigned by CMS, is used to uniquely identify the physician for Medicare billing purposes. Note: Data set will include capability to collect the National Provider Identifier (effective date, May 23, 2005; compliance date, May 23, 2007).
Cardiogenic shock?	On entry to the cath lab, is the patient in **cardiogenic shock**, which is systolic BP < 80 mmHg for more than 30 minutes, evidence of poor tissue perfusion and persistence of shock after correction of non-myocardial factors (hypovolemia, hypoxia, acidosis, arrhythmia) AND/OR IV inotropes and/or vasopressors and/or IABP required in order to maintain systolic BP > 80 mmHg?	-Yes -No	* Emergency department record * Cath lab log sheet * Cath/ PCI report	
Infarct-related artery segment	Identify the infarct-related artery segment and its most proximal reference number, using the codes provided.	1. Prox RCA 2. Mid RCA 3. Dist RCA 4. R PDA 5. Left main LAD 6. Prox LAD (before 1st septal) 7. Mid LAD 8. Apical LAD 9. 1st diag LAD 10. 2nd diag LAD 11. Prox Left CX 12. Marg CX 13. Dist CX 14. Posterolateral CX 15. Posterior descending CX 16. Saphenous vein graft 17. LIMA 18. Ramus intermedius segment - Ramus	* Cath/PCI report	
Intra-aortic Balloon Pump	An Intra-aortic Balloon Pump (IABP) was used prior, during or after the Cath Lab Visit.	- Yes - No	* Cath lab log sheet * Cath/PCI report	

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
GP IIb/IIIa inhibitor used	GP IIb/IIIa inhibitor was used during procedure.	-Yes -No	* Cath lab log sheet * Cath report * PCI report	
Number of vessels attempted	The number of vessels attempted to be treated: a guidewire was advanced beyond the tip of a guiding catheter.	0, 1, 2, 3, 4	* Cath report * PCI report	
If zero (no PCI attempt), why?	Reason for no PCI attempt	1. no CAD 2. >50% left main stenosis 3. 3-vessel CAD/"high risk" anatomy 4. IRA patent with TIMI 3 flow 5. IRA cannot be identified 6. severe CAD best treated with CABG 7. IRA small 8. too high risk 9. other	* Cath report	Specify 'other' reason in comments (free text).
Comments why no PCI attempt:	If the reason for no PCI attempt is different from the choices provided or further explanation is warranted utilize this space.	Free text	* Cath report	
Artery Segment Number	Identify segment(s) where PCI procedure was attempted and the most proximal reference number, using the codes provided.	1. Prox RCA 2. Mid RCA 3. Dist RCA 4. R PDA 5. Left main LAD 6. Prox LAD (before 1st septal) 7. Mid LAD 8. Apical LAD 9. 1st diag LAD 10. 2nd diag LAD 11. Prox Left CX 12. Marg CX 13. Dist CX 14. Posterolateral CX 15. Posterior descending CX 16. Saphenous vein graft 17. LIMA 18. Ramus intermedius segment - Ramus	* Cath report * PCI report	For each attempted lesion, use the list provided to identify segment(s) where PCI procedure was attempted.
PCI vessel other than IRA	The vessel being treated is not an infarct-related artery.	- Yes - No	* Cath report * PCI report	
Pre-PCI Diameter Stenosis Percent	The percent diameter stenosis in the treated segment pre-procedure	A continuous variable measured as a percentage (%).	* Cath report * PCI report	

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Pre-PCI TIMI Flow Grade	The pre-procedure blood flow, as assessed by the Thrombolysis in Myocardial Infarction (TIMI) flow grade	- TIMI-0: No flow/no perfusion. - TIMI-1: Slow penetration without perfusion. - TIMI-2: Partial flow/partial perfusion (greater than TIMI-1 but less than TIMI-3). - TIMI-3:Complete and brisk flow/complete perfusion.	* Cath report * PCI report	
Procedure performed		1. Balloon only 2. Atherectomy (including with balloon; excluding with stent) 3. Stent (alone or in any combination	* Cath report * PCI report	Atherectomy devices are excluded from use at pPCI waiver hospitals.
If stent was used, identify type:				
Bare metal stent		- Yes - No	* Cath report * PCI report	
Drug-eluting stent		- Yes - No	* Cath report * PCI report	
Thrombus removal device used	The device used to remove thrombus during PCI procedure	- Yes - No	* Cath report * PCI report	
Post-PCI Diameter Stenosis Percent	The percent diameter stenosis in the treated segment post-procedure	A continuous variable measured as a percentage (%).	* Cath report * PCI report	
Post-PCI TIMI Flow Grade	The post-procedure blood flow, as assessed by the Thrombolysis in Myocardial Infarction (TIMI) flow grade	- TIMI-0: No flow/no perfusion. - TIMI-1: Slow penetration without perfusion. - TIMI-2: Partial flow/partial perfusion (greater than TIMI-1 but less than TIMI-3). - TIMI-3:Complete and brisk flow/complete perfusion.	* Cath report * PCI report	
Successful PCI	Intervention defined as successful when < 50% residual stenosis and TIMI 3 flow	- Yes - No	* Cath report * PCI report	

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Returned to cath lab	The patient returned to the cath lab for either a relook (no intervention) or a repeat PCI	- With intervention (repeat PCI) - Without intervention - Did not return to cath lab	* Cath report * PCI report * Procedure notes	
Transferred for emergency CABG	The patient was transferred to a tertiary care hospital for emergency CABG.	- Yes - No	* Cath report * PCI report * Discharge summary	
Reason for Emergency Bypass Surgery	The reason the index hospital transferred the patient to a tertiary care hospital for CABG	- Severe CAD - Hemodynamic instability - Unable to keep IRA patent - Injury to vessel other than IRA - PCI-related complication other than PCI failed - Other	* Cath report * PCI report * Discharge summary * Transfer record	Scan signed authorization, transfer record, and discharge summary. Specify 'other' reason (free text). Provide comments as appropriate.
Index Discharge Form				
Date of Index Discharge	The date the patient was discharged from the index hospital	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2009)	* Discharge summary * Face sheet * Nursing discharge notes * Progress notes * Transfer note	If the patient died in the hospital, the hospital discharge date is the date of death.
Transfer to another hospital	The patient was transferred to a tertiary hospital for follow-up cardiac care.	- Yes - No	* Discharge summary * Face sheet * Nursing discharge notes * Progress notes * Transfer note	If the patient was transferred, complete the Transfer Hospital Discharge Data Form.
Death	The patient was diagnosed clinically dead.	- Yes - No	* Discharge summary * Death certificate	Complete relevant Event data form.
Recurrent MI	A suspected recurrent infarction event is defined as any episode of chest pain or new ECG changes thought to represent infarction that occurs **more than 18 hours after admission for the index infarction.**	-Yes -No	* Discharge summary	Complete relevant Event data form.
Stroke	Any neurological deficit present at the time of hospital discharge that was not present at admission. A neurological deficit requires objective determination of new aphasia, paralysis, paresis, ataxia, or blindness.	- Yes - No	* Discharge summary * Consultation notes * Nursing notes * Progress notes	Complete relevant Event data form.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Hemorrhage	Any one of the following: A loss of blood resulting in a decrease in hemoglobin of at least 5 or more g/dL; blood transfusion and/or need for vascular surgery; or retroperitoneal hemorrhage as a bleeding complication even if transfusion and/or vascular surgery are not necessary.	- Yes - No	* Discharge summary * Consultation notes * Nursing notes * Progress notes	Complete relevant Event data form.
Return to cath lab	The patient returned to the cath lab.	- Yes - No	* Cath report * PCI report * Procedure notes	
Repeat cath performed	The patient received a repeat cath during the same hospitalization.	- Yes - No	* Cath report * PCI report * Procedure notes	
Repeat PCI performed/ attempted	The patient received a repeat PCI or PCI attempt during the same hospitalization.	- Yes - No	* Cath report * PCI report * Procedure notes	PCI attempt: a guidewire as advanced beyond the tip of a guiding catheter.
CABG	The patient was required to have a CABG performed.	- Yes - No	* Discharge summary (from transfer hospital)	Complete relevant Event data form. Provide comments as appropriate.
Transfer Discharge Form				
Name of transfer hospital	The name of the hospital the patient was transferred to.	Values should be full, official hospital names with no abbreviations or variations in spelling for a single hospital.	* Discharge summary * Face sheet * Nursing discharge notes * Physician orders * Progress notes * Transfer note	Complete the data form only if the patient was transferred to another acute care hospital. Include only those events at the transfer hospital <u>after</u> <u>transfer</u>.
Date of Transfer Discharge	The date the patient was discharged from the transfer hospital.	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2009)	* Discharge summary	Scan discharge summary from transfer hospital.
Death	The patient was diagnosed clinically dead.	- Yes - No	* Discharge summary * Death certificate	Complete relevant Event data form.
Recurrent MI	A suspected recurrent infarction event is defined as any episode of chest pain or new ECG changes thought to represent infarction that occurs **more than 18 hours after admission for the index infarction.**	-Yes -No	* Discharge summary	Complete relevant Event data form.
Stroke	Any neurological deficit present at the time of hospital discharge that was not present at admission. A neurological deficit requires objective determination of new aphasia, paralysis, paresis, ataxia, or blindness.	- Yes - No	* Discharge summary	Complete relevant Event data form.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Hemorrhage	Any one of the following: A loss of blood resulting in a decrease in hemoglobin of at least 5 or more g/dL; blood transfusion and/or need for vascular surgery; or retroperitoneal hemorrhage as a bleeding complication even if transfusion and/or vascular surgery are not necessary.	- Yes - No	* Discharge summary	Complete relevant Event data form.
Cath lab visit	The patient went to the cath lab.	- Yes - No	* Discharge summary	
Repeat cath performed	The patient received a cath during the hospitalization.	- Yes - No	* Discharge summary	
PCI performed/ attempted	The patient received a PCI or a PCI attempt during the hospitalization.	- Yes - No	* Discharge summary	PCI attempt: a guidewire as advanced beyond the tip of a guiding catheter.
CABG	The patient was required to have a CABG performed.	- Yes - No	* Discharge summary * Operative report	Complete relevant Event data form. Provide comments as appropriate.
Follow-Up Data				
Date of Follow-up	The date that the follow-up was conducted	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2009)	* Follow-up phone call	Follow-up phone calls should occur 6 weeks (+/- 2 weeks) from the first PCI date.
Did the patient die since initial or index hospitalization?	The patient was diagnosed clinically dead.	- Yes - No	* Follow-up phone call	Complete relevant Event data form.
Since initial or index hospitalization has the patient had recurrent MI?	A suspected recurrent infarction event is defined as any episode of chest pain or new ECG changes thought to represent infarction that occurs **more than 18 hours after admission for the index infarction.**	-Yes -No	* Discharge summary	Complete relevant Event data form.
Since initial or index hospitalization has the patient had a stroke?	A new neurological deficit developed during the follow-up period. A neurological deficit requires objective determination of new aphasia, paralysis, paresis, ataxia, or blindness.	- Yes - No	* Follow-up phone call	Complete relevant Event data form.
Since initial hospitalization has the patient had hemorrhage?	Any one of the following: A loss of blood resulting in a decrease in hemoglobin of at least 5 or more g/dL; blood transfusion and/or need for vascular surgery; or retroperitoneal hemorrhage as a bleeding complication even if transfusion and/or vascular surgery are not necessary.	- Yes - No	* Discharge summary	Complete relevant Event data form.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Since initial hospitalization has the patient been taken to a cath lab?	The patient was readmitted for another cath lab visit.	- Yes - No	* Follow-up phone call	Complete relevant Event data form.
Since initial hospitalization has the patient had a cardiac catheterization performed?	The patient was readmitted for another cardiac catheterization.	- Yes - No	* Follow-up phone call	Complete relevant Event data form.
Since initial hospitalization has the patient had a PCI performed or attemped?	The patient was readmitted for another PCI or PCI attempt.	- Yes - No	* Follow-up phone call	Complete relevant Event data form.
Since initial hospitalization has the patient had a CABG?	The patient was readmitted for a CABG.	- Yes - No	* Follow-up phone call	Complete relevant Event data form.
Since initial hospitalization has the patient been hospitalized for any other reason?	The patient was readmitted to any hospital for any other reason.	- Yes - No	* Follow-up phone call	Complete relevant Event data form. Provide comments as appropriate.
Event Form - Death				
Death?	The patient was diagnosed clinically dead.	- Yes - No		
If yes, date of death	The date the patient was diagnosed clinically dead.	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2009)	* Any documentation of death	Scan documentation.
Timeframe	During which timeframe did event occur?	- Index hospitalization - Transfer hospitalization - Six week follow-up		
Place of Death	The location of the patient at the time of death.	- During lab visit (procedure at index hospital) - After lab visit, but before index hospital discharge - After index discharge - at another hospital - After index discharge - at home	* Any documentation of death	If the patient died during the index hospitalization, the location of the patient (in the cath lab or other in-hospital location) at the time of death. Provide comments as appropriate.
Event Form – Recurrent MI				
Recurrent MI?	Patient was diagnosed with recurrent MI.	- Yes - No		
If yes, date of recurrent MI	The date the patient experienced the recurrent MI.	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2009)	* Consultation notes * Nursing notes * Progress notes * Follow-up phone call	Scan ECGs, relevant notes (all chart notes and relevant consultations), and recorded CPK levels just before, during and 48 hours after the event.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Timeframe	During which timeframe did event occur?	- Index hospitalization - Transfer hospitalization - Six week follow-up		
				Provide comments as appropriate.
Event Form - Stroke				
Stroke?	Patient was diagnosed with stroke.	- Yes - No		
If yes, date of stroke	The date the patient experienced the stroke.	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2009)	* Consultation notes * Nursing notes * Progress notes * Follow-up phone call	Scan CT or MRI imaging report, relevant notes (all chart notes and relevant consultations).
Timeframe	During which timeframe did event occur?	- Index hospitalization - Transfer hospitalization - Six week follow-up		
				Provide comments as appropriate.
Event Form – Hemorrhage				
Hemorrhage?	Patient experienced hemorrhage.	- Yes - No		
If, yes, date of hemorrhage	The date the patient experienced the hemorrhage.	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2009)	* Consultation notes * Nursing notes * Progress notes * Follow-up phone call	Scan copies of transfusion slips, labs, procedure notes and operative reports.
Timeframe	During which timeframe did event occur?	- Index hospitalization - Transfer hospitalization - Six week follow-up		
				Provide comments as appropriate.
Event Form – Subsequent Cath and/or PCI				
Cath and/or PCI?	Patient experienced subsequent cath and/or PCI.	- Yes - No		
Timeframe	During which timeframe did event occur?	- Index hospitalization - Transfer hospitalization - Six week follow-up		
Catheterization performed?	The patient received a cardiac cath.	- Yes - No		
If yes, date of procedure	The date the procedure was performed	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2009)	* Cath report * PCI report	Scan catheterization and/or PCI report.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
PCI performed?	The patient received a PCI.	- Yes - No		
If yes, date of procedure	The date the procedure was performed	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2009)	* Cath report * PCI report	Scan catheterization and/or PCI report.
If yes, planned/scheduled?	The procedure was a planned (elective) procedure (and not an emergency procedure).	- Yes - No		
				Provide comments as appropriate.
Event Form - CABG				
CABG performed?	The patient received a CABG.	- Yes - No		
If yes, date of CABG	The date the CABG was performed	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2009)	* Operative report * Discharge summary	Scan operative report and discharge summary.
Timeframe	During which timeframe did event occur?	- Index hospitalization - Transfer hospitalization - Six week follow-up		
CABG priority classification	The CABG was emergent, urgent or elective.	- Emergent (ASAP after event) - Urgent (within 24 hours) - Elective	* Operative report * Discharge summary	Emergent means immediate or ASAP after event.
The reason the CABG was performed	The reason the CABG was performed	- Attempted but failed PCI - PCI not attempted due to high risk coronary anatomy - After successful PCI (for other vessel) - Recurrent ischemia or infarction - Development of heart failure - Development of shock - Papillary muscle rupture with mitral regurgitation, ventricular septal defect or ventricular rupture - Other	* Operative report * Discharge summary	Specify 'other' reason (free text).
				Provide comments as appropriate.

Name	Definition	Allowable Values	Suggested Data Source(s)	Notes for collection
Event Form - Other Readmission				
Other hospitalization since initial hospitalization?	The patient was readmitted to any hospital for any other reason.	- Yes - No	* Follow-up phone call	
If yes, date of other hospital admission	The date the patient was readmitted to any hospital for any other reason	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2009)		
Timeframe	During which timeframe did event occur?	- Index hospitalization - Transfer hospitalization - Six week follow-up		For any reasons other than the above events, indicate whether the patient was admitted after discharge from the index hospital or from the transfer hospital. Some hospitals may transfer while other hospitals discharge patients home to be readmitted in a few days. Provide comments as appropriate.